BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
Faramarz Alav, M.D.	)	**Case No. 800-2015-011002**
Physician's and Surgeon's Certificate No. A 74033	)	
Respondent	)	

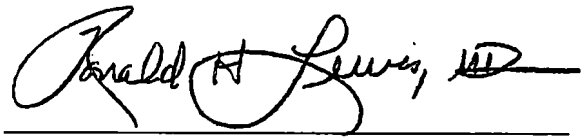
DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on September 6, 2019.

IT IS SO ORDERED: August 9, 2019.

MEDICAL BOARD OF CALIFORNIA



Ronald H. Lewis, M.D., Chair
Panel A

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: FARAMARZ ALAV, M.D. 16465 Sierra Lakes Pkwy #200 Fontana, California 92336 Physician's and Surgeon's Certificate No. A 74033, Respondent.	Case No. 800-2015-011002 OAH No. 2018050938 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Kimberly Kirchmeyer ("Complainant") is the Executive Director of the Medical Board of California ("Board"). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Claudia Ramirez, Deputy Attorney General.

2. Respondent Faramarz Alav, M.D. ("Respondent") is represented in this proceeding by attorney Tracy Green, Esq., whose address is: Green & Associates, 800 West 6th Street, Suite 450, Los Angeles, California, 90017.

3. On or about March 8, 2001, the Board issued Physician's and Surgeon's Certificate No. A 74033 to Respondent. That Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2015-011002, and will expire on January 31, 2021, unless renewed.

JURISDICTION

4. Accusation No. 800-2015-011002 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on January 8, 2018. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 800-2015-011002 is attached as Exhibit A and incorporated herein by reference.

ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2015-011002. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 800-2015-011002, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent does not contest that, at an administrative hearing, Complainant could establish a prima facie case with respect to the charges and allegations contained in Accusation No. 800-2015-011002 and that he has thereby subjected his license to disciplinary action.

11. Respondent agrees that if he ever petitions for early termination or modification of probation, or if the Board ever petitions for revocation of probation, all of the charges and allegations contained in Accusation No. 800-2015-011002 shall be deemed true, correct and fully admitted by Respondent for purposes of that proceeding or any other licensing proceeding involving Respondent in the State of California.

12. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CONTINGENCY

13. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

14. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Settlement and Disciplinary Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

15. In consideration of the foregoing admissions and stipulations, the parties agree that

the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A 74033 issued to Respondent Faramarz Alav, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for four (4) years on the following terms and conditions.

1. CONTROLLED SUBSTANCES - MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES. Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all of the following: 1) the name and address of the patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

2. EDUCATION COURSE. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 20 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 45 hours of CME of which 20 hours were in satisfaction of this condition.

3. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board

or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

5. MONITORING - PRACTICE. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to

cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

6. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to

Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

7. SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

8. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

9. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

10. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

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License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

11. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

12. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar

months, Respondent shall successfully complete the Federation of State Medical Boards's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

13. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

14. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

15. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent

shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

16. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Tracy Green, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 06/19/2019

FARAMARZ ALAV, M.D.
Respondent

I have read and fully discussed with Respondent Faramarz Alav, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 6/20/19

TRACY GREEN, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

DATED: 6/20/19

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
E. A. JONES III
Supervising Deputy Attorney General

Claudia Ramirez

CLAUDIA RAMIREZ
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2015-011002

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BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: FARAMARZ ALAV, M.D. 16465 Sierra Lakes Pkwy #200 Fontana, California 92336 Physician's and Surgeon's Certificate No. A 74033, Respondent.	Case No. 800-2015-011002 **ACCUSATION**

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer ("Complainant") brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs ("Board").

2. On or about March 8, 2001, the Medical Board issued Physician's and Surgeon's Certificate Number A 74033 to Faramarz Alav, M.D. ("Respondent"). That Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on January 31, 2019, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate.

"(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon the implementation of

the proposed registration program described in Section 2052.5.

"(h) The repeated failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board."

6. Section 725 of the Code states:

"(a) Repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, optometrist, speech-language pathologist, or audiologist.

"(b) Any person who engages in repeated acts of clearly excessive prescribing or administering of drugs or treatment is guilty of a misdemeanor and shall be punished by a fine of not less than one hundred dollars ($100) nor more than six hundred dollars ($600), or by imprisonment for a term of not less than 60 days nor more than 180 days, or by both that fine and imprisonment.

"(c) A practitioner who has a medical basis for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances shall not be subject to disciplinary action or prosecution under this section.

"(d) No physician and surgeon shall be subject to disciplinary action pursuant to this section for treating intractable pain in compliance with Section 2241.5."

7. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

PERTINENT DRUGS

8. The following drugs are classified as follows:

A. **Hydrocodone/Acetaminophen** (Norco, Lortab, Vicodin) is an opioid pain medication. It is a Schedule II controlled substance as defined by 21 Code of Federal Regulations

part 1308.12(b)(1)(vi) and Health and Safety Code section 11055, subdivision (b)(1)(I). It is a dangerous drug as defined in Business and Professions Code section 4022.

B. **Benzodiazepines** are a class of drugs that produce Central Nervous System depression and are most commonly used to treat insomnia and anxiety. Examples of benzodiazepines include **alprazolam** (e.g., Xanax) and **clonazepam** (Klonopin). They are classified as Schedule IV controlled substances as defined by 21 Code of Federal Regulations part 1308.14(c)(2) and (c)(11) and Health and Safety Code section 11057, subdivisions (d)(1) and (d)(7). They are dangerous drugs as defined in Business and Professions Code section 4022.

C. **Tramadol** (Ultram) is a narcotic-like pain reliever. It is a Schedule IV controlled substance as defined by 21 Code of Federal Regulations part 1308.14(b)(3). It is a dangerous drug as defined in Business and Professions Code section 4022.

D. **Zolpidem** (Ambien) is a sedative. It is a Schedule IV controlled substance as defined by 21 Code of Federal Regulations part 1308.14(c)(54) and Health and Safety Code section 11057, subdivision (d)(32). It is a dangerous drug as defined in Business and Professions Code section 4022.

E. **Carisoprodol** (Soma) is a muscle relaxant. It is a Schedule IV controlled substance as defined by 21 Code of Federal Regulations part 1308.14(c)(6) and Health and Safety Code section 11057, subdivision (d). It is a dangerous drug as defined in Business and Professions Code section 4022.

F. **Oxycodone Hydrochloride-Acetaminophen** (e.g., Percocet). Oxycodone is an opioid pain medication. Acetaminophen is a less potent pain reliever that increases the effects of oxycodone. Acetaminophen with oxycodone is a combination medicine used to relieve moderate to severe pain. Oxycodone is a Schedule II controlled substance as defined by 21 Code of Federal Regulations part 1308.12(b)(1)(xiii) and Health and Safety Code section 11055, subdivision (b)(1)(M). It is a dangerous drug as defined in Business and Professions Code section 4022.

G. **Oxycodone** (Oxycontin) is an opioid pain medication. It is a Schedule II controlled substance as defined by 21 Code of Federal Regulations part 1308.12(b)(1)(xiii) and Health and Safety Code section 11055, subdivision (b)(1)(M). It is a dangerous drug as defined in Business

and Professions Code section 4022.

H. Tylenol with Codeine is **acetaminophen with codeine.** Codeine is an opioid pain medication. Acetaminophen is a less potent pain reliever that increases the effects of codeine. Acetaminophen with codeine is a combination medicine used to relieve moderate to severe pain. It is a Schedule III controlled substance as defined by 21 Code of Federal Regulations part 1308.13(e)(1) and Health and Safety Code section 11056, subdivisions (e)(1) and (e)(2). It is a dangerous drug as defined in Business and Professions Code section 4022.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence-Patients A and B)

9. Respondent Faramarz Alav, M.D. is subject to disciplinary action under section 2234, subdivision (b), of the Code in that he was grossly negligent in the care and treatment of patients A and B.[1] The circumstances are as follows:

Patient A

10. From on or about September 4, 2013, through on or about November 6, 2014, Respondent treated Patient A, a then twenty-six-year-old female. Patient A's medical problems included anxiety, depression, back pain, and an ovarian cyst. She had been involved in a car accident in 2010. Her prior physician prescribed Vicodin 5/500 and Xanax 2 mg. Respondent refilled Hydrocodone Bitartrate-Acetaminophen 500 mg-5 mg, 90 tablets.

11. On or about September 6, 2013, Respondent refilled Alprazolam 0.25 mg, 30 tablets.

12. On or about September 26, 2013, Respondent refilled Hydrocodone Bitartrate--Acetaminophen 500 mg-5 mg, 90 tablets.

13. On or about October 2, 2013, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 500 mg-5 mg, 90 tablets.

14. On or about October 10, 2013, Respondent refilled Alprazolam 0.25 mg, 30 tablets.

15. On or about October 22, 2013, Respondent refilled Alprazolam 0.5 mg, 30 tablets.

16. On or about October 31, 2013, Respondent refilled Hydrocodone Bitartrate-

[1] The patients' names are not used in order to protect their right of privacy.

Acetaminophen 500 mg-5 mg, 90 tablets.

17. On or about November 7, 2013, Respondent refilled Alprazolam 0.25 mg, 30 tablets.

18. On or about November 19, 2013, Respondent refilled Alprazolam 0.25 mg, 60 tablets, and Hydrocodone Bitartrate-Acetaminophen 300 mg-5 mg, 60 tablets. He also prescribed Tramadol 50 mg, 90 tablets, 3 refills.

19. On or about November 26, 2013, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 500 mg-5 mg, 90 tablets.

20. On or about December 6, 2013, Respondent refilled Alprazolam 0.25 mg, 30 tablets.

21. On or about December 18, 2013, Respondent refilled Alprazolam 0.25 mg, 60 tablets.

22. On or about December 23, 2013, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 500 mg-5 mg, 90 tablets.

23. On or about January 17, 2014, Respondent refilled Alprazolam 0.25 mg, 60 tablets.

24. On or about January 20, 2014, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 500 mg-5 mg, 90 tablets.

25. On or about January 30, 2014, Respondent prescribed Citalopram 20 mg, 30 tablets, and Tramadol 50 mg, 120 tablets, 3 refills. He refilled Alprazolam 0.25 mg, 30 tablets.

26. On or about February 4, 2014, Respondent refilled Alprazolam 0.25 mg, 60 tablets.

27. On or about February 12, 2014, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 300 mg-5 mg, 60 tablets.

28. On or about February 19, 2014, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 500 mg-5 mg, 90 tablets.

29. On or about February 23, 2014, Respondent refilled Alprazolam 0.25 mg, 60 tablets.

30. On or about February 25, 2014, Respondent refilled Alprazolam 0.25 mg, 60 tablets.

31. On or about March 3, 2014, Patient A had a consultation with Dr. C.M., a pain management expert. Dr. C.M. ordered a drug screen and ran a Controlled Substance Utilization Review and Evaluation System ("CURES") report.[2] He noted that Patient A provided

[2] CURES refers to the Controlled Substance Utilization Review and Evaluation System, which is a government database containing information on Schedule II through IV controlled (continued...)

information inconsistent with what her pharmacy informed him. She lied about stopping her opioids. A urine drug screen revealed that she was positive for opioids. He diagnosed her with Myofascial pain, Lumbago, Thoracic spine pain, and long-term current use of opiate analgesic. He advised her to discontinue the Hydrocodone since her pain was nonspecific and did not justify the continued used of an opioid. He further recommended that she see a rheumatologist for diffuse muscle and joint pains.

32. Despite Dr. C.M.'s opinion that Patient A did not require opioid medications and should be tapered off them, Respondent continued to prescribe the same opioid medications.

33. On or about March 13, 2014, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 300 mg-5 mg, 60 tablets.

34. On or about March 19, 2014, Respondent refilled Alprazolam 0.25 mg, 60 tablets.

35. On or about March 28, 2014, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 300 mg-5 mg, 90 tablets.

36. On or about April 21, 2014, Respondent refilled Alprazolam 0.25 mg, 60 tablets, and Alprazolam 0.5 mg, 30 tablets. He also refilled Tramadol 50 mg, 90 tablets, 3 refills.

37. On or about April 25, 2014, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 300 mg-5 mg, 60 tablets.

38. On or about May 1, 2014, Patient A was treated in a hospital's Emergency Room for a new onset epileptic seizure. A drug screen detected benzodiazepines and opiates.

39. On or about May 2, 2014, Respondent refilled Vicodin ES 300 mg-7.5 mg, 90 tablets.

40. On or about May 20, 2014, Respondent refilled Alprazolam 0.5 mg, 30 tablets.

41. On or about May 27, 2014, Respondent refilled Vicodin ES 300 mg-7.5 mg, 90 tablets.

42. On or about June 18, 2014, Respondent refilled Alprazolam 0.5 mg, 30 tablets.

43. On or about June 19, 2014, Respondent refilled Alprazolam 0.25 mg, 60 tablets.

44. On or about June 24, 2014, Respondent refilled Vicodin ES 300 mg-7.5 mg, 90

(...continued)
substances dispensed in California.

tablets.

45. On or about July 7, 2014, Respondent refilled Alprazolam 2 mg, 60 tablets, and Hydrocodone Bitartrate-Acetaminophen 325 mg-10 mg, 90 tablets.

46. On or about July 24, 2014, Respondent refilled Alprazolam 0.5 mg, 30 tablets, and Hydrocodone Bitartrate-Acetaminophen 325 mg-5 mg, 30 tablets.

47. On or about July 29, 2014, Respondent refilled Alprazolam 0.5 mg, 60 tablets, and Vicodin 300 mg-5 mg, 90 tablets.

48. On or about August 8, 2014, Respondent refilled Alprazolam 0.5 mg, 60 tablets.

49. On or about August 30, 2014, Respondent refilled Alprazolam 0.5 mg, 60 tablets, and Vicodin 300 mg-5 mg, 90 tablets.

50. On or about September 12, 2014, Respondent refilled Acetaminophen/Codeine, 300 mg-30 mg, 90 tablets.

51. On or about October 13, 2014, Respondent refilled Alprazolam 0.5 mg, 60 tablets.

52. Respondent treated Patient A for chronic pain. His history taking and physical examinations of Patient A were inadequate. His documentation lacked legibility, thoroughness, accuracy, and comprehensiveness in its scope. There is no documentation of a functional assessment. Respondent's diagnosis for Patient A lacked clarity and specificity. It was not correlated to the documentation of the physical exam. Based on the documentation in Respondent's medical records for Patient A, her treatment plan did not require long-term opioid treatment. The documentation of the opioid prescriptions and re-fills were at times illegible, unclearly dated, and inaccurate.

53. Documentation of a functional assessment, notation of pain using a visual analog pain scale, an opioid contract, a urine drug test, or a CURES report obtained by Respondent are not in his medical records for Patient A. There is also no documentation of substantive questions exploring the nature of Patient A's anxiety, inquiry about major depression, or evaluation of mood with a Patient Health Questionnaire-9 ("PHQ-9"). Respondent failed to quantify Patient A's baseline level of pain or how effective the opioid was in lowering the pain using a visual analog pain scale. He failed to document adverse reactions or side effects on a regular basis.

54. Respondent failed to appropriately evaluate Patient A's actual need for long-term opioid therapy. There is little documentation in his medical records for her regarding any conservative therapy that was tried and failed. The pain management consultant, whom Respondent recommended for Patient A to see, stated that her back pain was nonspecific and she did not require opioid treatment. Nevertheless, Respondent continued to prescribe the same opioid for months. On many encounters, Patient A's opioid prescriptions contained 2 or 3 refills, which meant that Patient A would not have to be seen in a face-to-face visit in order to continue taking the opioids.

55. Patient A exhibited aberrant drug-taking behavior (she lied about stopping her opioid), which the pain management consultant documented in his consultation note dated March 3, 2014. However, Respondent failed to take appropriate action as the opioid-prescribing physician. Eventually, on or about October 13, 2014, another clinician at his office ran a CURES report and uncovered additional evidence of inappropriate opioid seeking behavior; only then, in the presence of this other clinician, did Respondent confront Patient A about asking for and receiving opioids from multiple prescribers. Respondent did not document the need for Patient A to be tapered off the opioids.

56. Benzodiazepines can and do lower the seizure threshold. At the emergency room where Patient A was first treated and diagnosed with a seizure disorder, the clinician there opined that the seizure was a result of a drug. Respondent did not appropriately address this, and he continued to prescribe her benzodiazepines, even though she was not on a therapeutic dose or even a daily dose of an antiepileptic drug. Chronic benzodiazepine dependence posed a particular risk factor to this patient's neurologic care.

57. Patient A's initial chief complaints included anxiety and depression. Respondent's issues with his assessment and treatment began during the first and third visits. Her previous doctor refilled Xanax 2 mg. Respondent did try to treat her with a number of Selective serotonin reuptake inhibitors[3] initially. His documentation is not clear what he did with the Xanax

[3] Selective serotonin reuptake inhibitors are the most commonly refilled antidepressants.

prescription.

58. Respondent improperly evaluated Patient A for her anxiety and possible major depression. Patient A was never evaluated with a simple questionnaire like a PHQ-9. Respondent later continued chronic benzodiazepine therapy. Benzodiazepine therapy subjects a patient to the hazards of addiction, dependence, accidental overdoses, and loss of consciousness. Benzodiazepine can make major depression worse. Seizures can and do occur if doses are missed. Patient A had two documented seizure episodes: on or about May 1, 2014, and on or about November 5, 2014. The second occurred when she was not on a regular dose of an antiepileptic drug, but was receiving a daily benzodiazepine.

59. Patients with chronic pain often have major depression. Whenever anxiety drugs or antidepressant agents fail to bring relief and improve function, a consultation with a psychiatric specialist should be ordered. That did not occur until many months after Respondent had been treating Patient A.

60. Patient A was a good candidate for weaning from her hydrocodone and alprazolam dependence. The pain management specialist recommended early on that chronic opioid therapy was not medically necessary. Respondent's medical records for Patient A do not show that she benefitted from long-term opioid and alprazolam treatment, because there was no documentation that the pain was well-controlled or of a return to function. One of the major reasons physicians are cautioned against long term benzodiazepine treatment is that any iatrogenic-[4] or patient-caused cessation of benzodiazepine use can cause an epileptic seizure. This exact event may have caused Patient A's seizure disorder. By continuing to prescribe the alprazolam, Respondent may have hindered the control of Patient A's seizure disorder.

61. Patient A continued to receive prescriptions of opioids along with benzodiazepines from Respondent. Patients taking chronic opioid therapy should avoid taking benzodiazepines because that combination is associated with bad outcomes, including death.

62. Respondent engaged in an extreme departure from the standard of care in the

[4] Iatrogenic means relating to illness caused by medical examination or treatment.

assessment and care of Patient A, who had chronic nonspecific low back pain and who was dependent on opioids and benzodiazepine drugs.

63. Respondent engaged in an extreme departure from the standard of care in not recommending that Patient A wean from the opioid medications.

Patient B

64. From on or about January 3, 2011, through on or about February 29, 2016, Respondent treated Patient B, a then 66-year-old male. Patient B's medical problems included: type 2 diabetes with complications (peripheral neuropathy and angiopathy); chronic low back pain with opioid and muscle relaxant dependence; insomnia with benzodiazepine dependence; gait disturbance; hypertension; coronary artery disease; and hemiplegia as a late manifestation of two cerebrovascular accidents (also known as a stroke). Patient B also had cholelithiasis (gallstones); morbid obesity; and Chronic Obstructive Pulmonary Disease with chronic respiratory failure later on in his clinical history.

65. The handwritten documentation of Respondent's encounters with Patient B are very difficult to read. The physical examination's documentation is very sparse throughout all of the encounters. The documentation consists of a few words which are usually illegible. The assessment (diagnosis) is stated in the same terms visit after visit and do not match what the specialists have stated. It is extremely difficult to know which medications the patient was taking, at what dosage, or at what frequency.

66. On or about October 14, 2012, Respondent refilled Carisoprodol, 350 mg, 120 tablets.

67. On or about October 17, 2012, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 325 mg-10 mg, 120 tablets, and Oxycontin 80 mg, 120 tablets.

68. On or about November 15, 2012, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 325 mg-10 mg, 120 tablets.

69. On or about November 20, 2012, Respondent refilled Oxycontin 80 mg, 120 tablets.

70. On or about December 11, 2012, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 325 mg-10 mg, 120 tablets.

71. On or about December 17, 2012, Respondent refilled Oxycontin 80 mg, 120 tablets.

72. On or about January 8, 2013, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 325 mg-10 mg, 90 tablets.

73. On or about January 11, 2013, Respondent refilled Oxycontin 80 mg, 120 tablets.

74. On or about January 14, 2013, Respondent refilled Carisoprodol, 350 mg, 120 tablets.

75. On or about February 6, 2013, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 325 mg-10 mg, 90 tablets.

76. On or about February 8, 2013, Respondent refilled Oxycontin 80 mg, 120 tablets.

77. On or about February 12, 2013, Respondent refilled Carisoprodol, 350 mg, 120 tablets.

78. On or about March 6, 2013, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 325 mg-10 mg, 90 tablets.

79. On or about March 8, 2013, Respondent refilled Oxycontin 80 mg, 120 tablets.

80. On or about March 9, 2013, Respondent refilled Carisoprodol, 350 mg, 120 tablets.

81. On or about April 6, 2013, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 325 mg-10 mg, 120 tablets, and Oxycontin 80 mg, 120 tablets.

82. On or about April 9, 2013, Respondent refilled Carisoprodol, 350 mg, 120 tablets.

83. On or about May 3, 2013, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 325 mg-10 mg, 90 tablets.

84. On or about May 5, 2013, Respondent refilled Carisoprodol, 350 mg, 120 tablets.

85. On or about May 6, 2013, Respondent refilled Oxycontin 80 mg, 120 tablets.

86. On or about June 3, 2013, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 325 mg-10 mg, 90 tablets, and Oxycontin 80 mg, 120 tablets.

87. On or about June 4, 2013, Respondent refilled Carisoprodol, 350 mg, 120 tablets.

88. On or about July 1, 2013, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 325 mg-10 mg, 90 tablets, and Oxycontin 80 mg, 120 tablets.

89. On or about July 2, 2013, Respondent refilled Carisoprodol, 350 mg, 120 tablets.

90. On or about July 20, 2013, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 325 mg-10 mg, 90 tablets.

91. On or about July 30, 2013, Respondent refilled Carisoprodol, 350 mg, 120 tablets.

92. On or about August 1, 2013, Respondent refilled Oxycontin 80 mg, 120 tablets.

93. On or about August 28, 2013, Respondent refilled Oxycontin 80 mg, 120 tablets.

94. On or about August 29, 2013, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 325 mg-10 mg, 90 tablets, and Carisoprodol, 350 mg, 120 tablets.

95. On or about September 10, 2013 and October 7, 2013, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 325 mg-10 mg, 90 tablets, and Oxycontin 80 mg, 120 tablets.

96. On or about January 23, 2014, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 325 mg-10 mg, 90 tablets, and Oxycontin 80 mg, 120 tablets.

97. On or about February 20, 2014, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 325 mg-10 mg, 90 tablets, and Oxycontin 80 mg, 120 tablets.

98. On or about March 17, 2014, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 325 mg-10 mg, 90 tablets.

99. On or about March 20, 2014, Respondent refilled Oxycontin 80 mg, 120 tablets.

100. On or about June 27, 2014, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 325 mg-10 mg, 90 tablets, and Oxycontin 80 mg, 120 tablets.

101. On or about July 20, 2014, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 325 mg-10 mg, 90 tablets.

102. On or about August 9, 2014, Respondent refilled Oxycontin, 80 mg, 120 tablets.

103. On or about August 20, 2014, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 325 mg-10 mg, 90 tablets.

104. On or about September 8, 2014, Respondent refilled Carisoprodol 350 mg, 90 tablets, and Oxycontin, 80 mg, 120 tablets.

105. On or about September 12, 2014, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 325 mg-10 mg, 90 tablets.

106. On or about October 7, 2014; November 2, 2014; November 26, 2014; and December 26, 2014, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 325 mg-10 mg, 90 tablets,

and Oxycontin 80 mg, 120 tablets.

107. On or about January 26, 2015; February 20, 2015; March 20, 2015; April 15, 2015; May 18, 2015; June 10, 2015; July 3, 2015; August 3, 2015; September 1, 2015; September 25, 2015; October 26, 2015; November 22, 2015; December 16, 2015; January 19, 2016; and February 10, 2016, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 325 mg-10 mg, 90 tablets, and Oxycontin 80 mg, 120 tablets.

108. Patient B developed cardiovascular complications: diabetic angiopathy, a heart attack, and a stroke. The care of a diabetic patient involves active surveillance for and treatment of risk factors for common complications. Preventive medicine can help a patient avoid complications. The monofilament examination of the feet, evaluating the peripheral circulation, and examining the skin in the lower extremities, to name a few issues, should be carefully performed and documented. An adult diabetic is at risk for cardiovascular complications. Typically, an angiotensin converting enzyme inhibitor, low dose aspirin, and a statin are prescribed. Tobacco smokers are at elevated risk and smoking cessation should be recommended. Respondent failed to properly address or document these clinical tasks.

109. Chronic pain requires an accurate and detailed history, past medical history, review of systems, occupational history, drug history, history of prior treatments tried and failed, and inquiry into activities of daily living, known triggers and relievers of the pain. Any ongoing Workman's Compensation claims, past or present need to be discussed. Any psychiatric issues should be explored as well. A PHQ-9 questionnaire is recommended as a means to uncover major depression, which is common in patients with chronic pain. Issues of substance use and abuse are also very important, as is the patient's work and marital status. Any laboratory testing and imaging should be reviewed. The physical examination should be systems-based and thorough and should include range of motion, deformities, posture, gait, and a detailed neurologic exam. Respondent failed to properly address or document these clinical tasks.

110. Patient B received prescriptions for high dosages of two opioids and a muscle relaxer for years. He probably had alcoholism as well. He was diagnosed with alcohol withdrawal during a September 29, 2013, hospitalization for abdominal pain and difficulty breathing. A

CAGE questionnaire[5] is recommended to look for evidence of alcohol or other substance abuse issues for patients on chronic and high dose opioids. That was not done.

111. Patient B's daily opioid dose was extremely high. The opioid guidelines warn that a Morphine Equivalent Dose[6] above 100 mg carries risks to the patient. Patient B's daily morphine equivalent dose was around 420 mg. In addition, he took four 350 mg tablets of Soma, which is converted in the body to another sedating drug, meprobamate. Patients who take high doses of opioids are at risk for accidental overdose and death. A fundamental requirement for staying on opioids is the demonstration that they provide effective analgesia and an improvement of function. Respondent failed to document that information in Patient B's medical records. The 4A's of documentation (Analgesia, Activity level, Adverse reactions, and Aberrant drug taking behavior) create a trusted foundation for proper oversight and ongoing evaluation of the effectiveness and appropriateness of opioid medications for the chronic pain patient who receives opioid treatment. That data can unmask opioid misuse and addiction behavior. The prescribing physician is expected to check CURES on a regular basis and to run a urine drug test periodically to look for medication misuse.

112. The combination of alcohol abuse or alcoholism, high daily opioid use, and muscle relaxers is a high-risk pharmacological setting. Patient B deserved additional counselling and referral to a pain management expert, who could have addressed the high-risk nature of that treatment plan.

113. Respondent engaged in an extreme departure from the standard of care in caring for Patient B's diabetic complications.

114. Respondent engaged in an extreme departure from the standard of care in the management of Patient B's opioid and muscle relaxant medications.

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[5] The CAGE questionnaire, the name of which is an acronym of its four questions, is a widely used screening test for problem drinking and potential alcohol problems.

[6] Morphine is an opioid pain medication. Morphine Equivalent Dose ("MED") of opioids is a numerical standard against which most opioids can be compared, giving an apples-to-apples comparison of each medication's potency. By converting the dose of an opioid to a morphine equivalent dose, a clinician can determine whether a cumulative daily dose of opioids approaches an amount associated with increased risk.

115. Respondent's acts and/or omissions as set forth in paragraphs 10 through 114, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute grossly negligent acts pursuant to section 2234, subdivision (b), of the Code with respect to patients A and B. Therefore, cause for discipline exists.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts-Patients A, B, and C)

116. Respondent Faramarz Alav, M.D. is subject to disciplinary action under Code section 2234, subdivision (c), in that Respondent engaged in repeated negligent acts in the care and treatment of patients A, B and C. The circumstances are as follows:

117. The facts and allegations in Paragraphs 10 through 114, above, are incorporated by reference and re-alleged as if fully set forth herein.

Patient A

118. Respondent engaged in a departure from the standard of care for inadequate medical record-keeping.

119. Respondent engaged in a departure from the standard of care for failure to appropriately screen Patient A as a suitable candidate for ongoing opioid therapy.

120. Respondent engaged in a departure from the standard of care in the treatment of Patient A's seizure disorder.

121. Respondent engaged in a departure from the standard of care in the delay in diagnosis and referral for Patient A's chronic anxiety and benzodiazepine dependence.

Patient B

122. Respondent engaged in a departure from the standard of care for inadequate medical record-keeping.

123. Respondent engaged in a departure from the standard of care in the management of Patient B's underlying alcoholism.

Patient C

124. From on or about January 7, 2011, to on or about February 29, 2016, Respondent treated Patient C, a then 67-year-old female. The handwritten documentation of Respondent's

encounters with Patient C is very difficult to read. The physical examination's documentation is very sparse throughout all of the encounters. The documentation consists of a few words which are usually illegible. The assessment (diagnosis) and plans are unclear. It is extremely difficult to know which medications the patient was taking, at what dosage, or at what frequency.

125. On or about October 21, 2012; November 5, 2012; December 5, 2012; and January 4, 2013, Respondent refilled Clonazepam 0.5 mg, 60 tablets.

126. On or about January 17, 2013, Respondent prescribed Hydrocodone Bitartrate-Acetaminophen 750 mg-7.5 mg, 60 tablets.

127. On or about February 1, 2013; February 28, 2013; March 25, 2013; and April 23, 2013, Respondent refilled Clonazepam 0.5 mg, 60 tablets.

128. On or about April 29, 2013, Respondent prescribed Oxycodone Hcl-Acetaminophen 325 mg-10 mg, 60 tablets.

129. On or about May 21, 2013, and June 18, 2013, Respondent refilled Clonazepam 0.5 mg, 60 tablets.

130. On or about June 21, 2013, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 750 mg-7.5 mg, 60 tablets.

131. On or about July 10, 2013, Respondent refilled Clonazepam 0.5 mg, 60 tablets.

132. On or about July 16, 2013, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 750 mg-7.5 mg, 60 tablets.

133. On or about August 14, 2013; September 11, 2013; October 8, 2013; and November 6, 2013, Respondent refilled Clonazepam 0.5 mg, 60 tablets, and Hydrocodone Bitartrate-Acetaminophen 750 mg-7.5 mg, 60 tablets. He also prescribed Alprazolam, 0.5 mg, 30 tablets.

134. On or about November 20, 2013, Respondent refilled Alprazolam, 0.5 mg, 30 tablets.

135. On or about December 2, 2013, Respondent refilled Clonazepam 0.5 mg, 60 tablets, and Hydrocodone Bitartrate-Acetaminophen 750 mg-7.5 mg, 60 tablets.

136. On or about December 16, 2013, Respondent refilled Alprazolam, 0.5 mg, 30 tablets.

137. On or about December 30, 2013, Respondent refilled Clonazepam 0.5 mg, 60 tablets, and Hydrocodone Bitartrate-Acetaminophen 750 mg-7.5 mg, 60 tablets.

138. On or about January 2, 2014, Respondent refilled Alprazolam, 0.5 mg, 30 tablets.

139. On or about January 28, 2014, Respondent refilled Clonazepam 0.5 mg, 60 tablets; Alprazolam, 0.5 mg, 30 tablets; and Hydrocodone Bitartrate-Acetaminophen 750 mg-7.5 mg, 60 tablets.

140. On or about February 25, 2014, Respondent refilled Clonazepam 0.5 mg, 60 tablets; Alprazolam, 0.5 mg, 30 tablets; and Hydrocodone Bitartrate-Acetaminophen 325-7.5 mg, 60 tablets.

141. On or about March 19, 2014, and April 16, 2014, Respondent refilled Clonazepam 0.5 mg, 60 tablets, and Alprazolam, 0.5 mg, 30 tablets.

142. On or about May 15, 2014, Respondent refilled Clonazepam 0.5 mg, 60 tablets; Alprazolam, 0.5 mg, 30 tablets; and Hydrocodone Bitartrate-Acetaminophen 325-7.5 mg, 60 tablets.

143. On or about June 2, 2014, Respondent refilled Alprazolam, 0.5 mg, 60 tablets.

144. On or about June 12, 2014, Respondent refilled Alprazolam, 0.5 mg, 30 tablets, and Hydrocodone Bitartrate-Acetaminophen 325-7.5 mg, 60 tablets.

145. On or about July 10, 2014, Respondent refilled Alprazolam, 0.5 mg, 30 tablets, and Hydrocodone Bitartrate-Acetaminophen 325-7.5 mg, 60 tablets.

146. On or about July 30, 2014, Respondent refilled Alprazolam, 0.5 mg, 30 tablets.

147. On or about August 7, 2014, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 325-7.5 mg, 60 tablets.

148. On or about August 18, 2014, Respondent refilled Alprazolam, 0.5 mg, 30 tablets.

149. On or about September 2, 2014, Respondent refilled Alprazolam, 0.5 mg, 60 tablets, and Hydrocodone Bitartrate-Acetaminophen 325-7.5 mg, 60 tablets.

150. On or about September 23, 2014, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 325-7.5 mg, 90 tablets.

151. On or about October 1, 2014; October 28, 2014; November 24, 2014; December 23, 2014; and January 21, 2015, Respondent refilled Alprazolam, 0.5 mg, 60 tablets.

152. On or about January 23, 2015, Respondent refilled Hydrocodone Bitartrate-

Acetaminophen 325 mg-7.5 mg, 90 tablets.

153. On or about February 18, 2015, Respondent refilled Alprazolam, 0.5 mg, 60 tablets.

154. On or about February 20, 2015, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 325 mg-7.5 mg, 90 tablets.

155. On or about March 19, 2015, Respondent refilled Alprazolam, 0.5 mg, 60 tablets, and Hydrocodone Bitartrate-Acetaminophen 325 mg-10 mg, 90 tablets.

156. On or about April 17, 2015, Respondent refilled Alprazolam, 0.5 mg, 60 tablets.

157. On or about April 21, 2015, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 325 mg-10 mg, 90 tablets.

158. On or about May 5, 2015, Respondent refilled Alprazolam, 0.5 mg, 60 tablets.

159. On or about May 14, 2015, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 325 mg-10 mg, 120 tablets.

160. On or about May 28, 2015, Respondent refilled Alprazolam, 0.5 mg, 60 tablets.

161. On or about June 18, 2015, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 325 mg-10 mg, 120 tablets.

162. On or about June 29, 2015, and July 22, 2015, Respondent refilled Alprazolam, 0.5 mg, 60 tablets.

163. On or about August 7, 2015, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 325 mg-10 mg, 90 tablets.

164. On or about August 17, 2015, Respondent refilled Alprazolam, 0.5 mg, 60 tablets.

165. On or about September 11, 2015, Respondent refilled Alprazolam, 0.5 mg, 60 tablets.

166. On or about September 21, 2015, Respondent refilled Hydrocodone Bitartrate-Acetaminophen 325 mg-10 mg, 90 tablets.

167. Chronic pain requires an accurate and detailed history, past medical history, review of systems, occupational history, drug history, a history of prior treatments tried and failed, and inquiry into activities of daily living, known triggers and relievers of the pain. Any ongoing Workman's Compensation claims, past or present need to be discussed. Any psychiatric issues should be explored as well. A PHQ-9 questionnaire is recommended as a means to uncover major

depression, which is common in patients with chronic pain. Issues of substance use and abuse are also very important, as is the patient's work and marital status. Any laboratory testing and imaging should be reviewed. The physical examination should be systems-based and thorough and should include range of motion, deformities, posture, gait, and a detailed neurologic exam. There was no functional assessment at all. There was no documentation of how well the opioid reduced the pain or improved function. These clinical tasks were not performed or documented.

168. This 73-year-old woman was at risk for complications from treatment with opioids and a benzodiazepine drug given at the same time. Patients with chronic pain who are prescribed opioids face a higher risk of complications, injuries, and poorer outcomes when they receive benzodiazepines along with their opioids. There is no evidence of any discussion or documentation of that potential for harm. The sedation and loss of coordination from each drug is magnified when both are taken daily, as this patient did.

169. The combining of an opioid with a benzodiazepine is risky, especially in the elderly. This patient deserved additional counselling and referral to a pain management expert, who could have addressed the high-risk nature of this treatment plan. Abrupt cessation of a benzodiazepine can trigger a seizure. Accidental overdose can result in loss of consciousness with head injury and orthopedic fractures, and the risk of death is high in this clinical setting.

170. The care of Patient C's diabetes is difficult to follow in the documentation. There is no documented basis for other diagnoses that may have been complications of diabetes. One example is "peripheral neuropathy" on August 14, 2014. There is no discussion of the etiology, the evidence on the physical exam, any testing, or the management plan.

171. Respondent engaged in a departure from the standard of care for inadequate medical record keeping.

172. Respondent engaged in a departure from the standard of care in caring for the diabetic complications of Patient C.

173. Respondent's acts and/or omissions as set forth in paragraphs 117 through 172, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute repeated negligent acts pursuant to section 2234, subdivision (c), of the Code with respect to

patients A, B, and C. Therefore, cause for discipline exists.

THIRD CAUSE FOR DISCIPLINE

(Incompetence-Patients A, B, and C)

174. Respondent Faramarz Alav, M.D. is subject to disciplinary action under section 2234, subdivision (d), of the Code for incompetence with respect to patients A, B, and C. The circumstances are as follows:

175. The facts and allegations in Paragraphs 10 through 114 and 117 through 172, above, are incorporated by reference and re-alleged as if fully set forth herein.

Patient A

176. Respondent showed a lack of knowledge in the failure to adequately provide ongoing assessment and evaluation of the effectiveness and appropriate use of the medications prescribed to Patient A. Three clinicians in the community uncovered the patient's opioid misuse and drug seeking behavior, which Respondent failed to do. In the first instance, the pain management clinician who Respondent chose was the one who initially uncovered this fact and shared it with Respondent.

Patient B

177. Respondent showed a lack of knowledge in the management and surveillance of Patient B's opioid treatment.

Patient C

178. Respondent showed a lack of knowledge in the management and surveillance of Patient C's opioid treatment.

179. Respondent showed a lack of knowledge in the management of Patient C's concomitant opioid and benzodiazepine treatment.

180. Respondent's acts and/or omissions as set forth in paragraph 175 through 179, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute incompetence pursuant to section 2234, subdivision (d), of the Code with respect to patients A, B, and C. Therefore, cause for discipline exists.

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FOURTH CAUSE FOR DISCIPLINE

(Excessive Prescribing-Patients A, B, and C)

181. Respondent Faramarz Alav, M.D. is subject to disciplinary action under section 725 of the Code for repeated acts of clearly excessive prescribing of controlled substances with respect to patients A, B, and C. The circumstances are as follows:

182. The facts and allegations in Paragraphs 10 through 114 and Paragraphs 117 through 172, above, are incorporated by reference and re-alleged as if fully set forth herein.

183. Respondent's acts and/or omissions as set forth in paragraphs 182, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute repeated acts of clearly excessive prescribing pursuant to section 725 of the Code with respect to patients A, B, and C. Therefore, cause for discipline exists.

FIFTH CAUSE FOR DISCIPLINE

(Inadequate and Inaccurate Recordkeeping-Patients A, B, and C)

184. Respondent Faramarz Alav, M.D. is subject to disciplinary action under section 2266 of the Code in that Respondent failed to maintain adequate and accurate medical records with respect to patients A, B, and C. The circumstances are as follows:

185. The facts and allegations in Paragraphs 10 through 114 and Paragraphs 117 through 172, above, are incorporated by reference and re-alleged as if fully set forth herein.

186. Respondent's acts and/or omissions as set forth in paragraph 185, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute inadequate and inaccurate record keeping pursuant to section 2266 of the Code with respect to patients A, B, and C. Therefore, cause for discipline exists.

SIXTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct-Patients A, B, and C)

187. Respondent is subject to disciplinary action under section 2234 of the Code for unprofessional conduct with respect to patients A, B, and C. The circumstances are as follows:

188. The facts and allegations in Paragraphs 9 through 186, above, are incorporated by reference and re-alleged as if fully set forth herein.

189. Respondent's acts and/or omissions as set forth in paragraph 188, inclusive above, whether proven individually, jointly, or in any combination thereof, constitute unprofessional conduct pursuant to section 2234 of the Code with respect to patients A, B, and C. Therefore, cause for discipline exists.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 74033 issued to Respondent Faramarz Alav, M.D.;

2. Revoking, suspending or denying approval of Respondent Faramarz Alav, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering Respondent Faramarz Alav, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: January 8, 2018

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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